STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	05/24/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on May 24, 2023, it was determined that Redstone Highlands Health Care was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0640 SS=A		F 0640		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0640 SS=A	Continued from page 1 483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 0640	I hereby acknowledge the CMS 2567-A, issued to REDSTONE HIGHLANDS HEALTH CARE CTR for the survey ending 05/24/2023, AND attest that all deficiencies listed on the form will be corrected in a timely manner. This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Redstone Highlands Healthcare Center agrees with the allegations and citations listed on the statement of deficiencies. Redstone Highlands Healthcare Center maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Redstone Highlands Healthcare Center's written credible allegation of compliance. By submitting this plan of correction, Redstone Highlands	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0640 SS=A	Continued from page 2 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:	F 0640	Healthcare Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Redstone Highlands Healthcare Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. 1) The minimum data set (MDS) assessment (mandated assessments of residents' abilities and care needs) for resident 36 that was due for the discharge on 3/1/2023 was completed and submitted. 2) A sweep of discharged residents was conducted going back 30 days to ensure discharge MDS and ARD (Assessment Reference Date) is set for timely completion of the assessments and assessments were submitted timely. Identified issues were corrected at the time of discovery. 3) The Registered Nurse Assessment Coordinator (RNAC) was re-educated on the timeliness	

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F 0640 SS=A	Continued from page 3	F 0640	criteria portion of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, RAI-OBRA (Omnibus Budget Reconciliation Act) required assessment summary. The RNAC will review the "Clinical MDS Scheduler" report in electronic system daily on business days to ensure that all assessments are completed on time. The CMS (Centers for Medicare and Medicaid Services) "MDS 3.0 Assessments with Error Number" report will be run weekly to ensure timely completion of the MDS assessments. 4) The Nursing Home Administrator or designee will conduct audits to ensure that MDS assessments are completed on time weekly for 4 weeks then monthly for 2 months. Identified issues are addressed at time of discovery. 5) Audit results are reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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F 0640 SS=A	Continued from page 4 Based on review of the Resident Assessment Instrument Manual and residents' clinical records, as well as staff interviews, it was determined that the facility failed to complete and/or transmit Minimum Data Set (MDS) assessments to the required electronic system, the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System within the required time frame for one of 41 residents reviewed (Resident 36). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that Entry, Death in Facility, and Discharge tracking records must be completed and transmitted within 14 days of the Event Date (Section A1600 plus 14 days for Entry	F 0640		

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F 0640 SS=A	Continued from page 5 records, Section A2000 plus 14 days for Death in Facility records, and Section A2300 plus 14 days for Discharge records). A nurse's note for Resident 36, dated March 1, 2023, revealed that the resident was discharged to home from the facility. Review of the clinical record for Resident 36 revealed that a discharge tracking record was not completed as of May 24, 2023. Interview with the Clinical Health Navigator on May 14, 2023, at 3:31 p.m. confirmed that the discharge tracking record for Resident 36 was not completed within the required time frames. 28 Pa. Code 211.5(f) Clinical records.	F 0640		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 6 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1) A Minimum Data Set (MDS) assessment correction for section C0100 and section D were unable to be submitted for residents 15 and 21 because those assessments were not completed. A new quarterly assessment will be completed on residents 15 and 21 including completion of sections C0100 and section D. A Minimum Data Set assessment correction for section N0410G was submitted for resident 22. A Minimum Data Set assessment correction for section H0100D was submitted for resident 44. A Minimum Data Set assessment correction for section M0300G2 was submitted for resident 63. A Minimum Data Set assessment correction for section A2100 was submitted for resident 66. A Minimum Data Set assessment correction for section B0300 was submitted for resident 75. 2) The Registered Nurse Assessment Coordinator will audit most recent Minimum Data Set Assessment for current residents to validate sections C0100, D, N0410G,	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0641 SS=D	Continued from page 7	F 0641	M0300G2 and B0300, H0100D, A2100. Concerns will be corrected upon discovery. 3) The Director of Risk Management will re-educate the Registered Nurse Assessment Coordinator concerning Minimum Data Set sections C0100, D, N0410G, M0300G2 and B0300 accuracy. 4) The Clinical Consultant will conduct a random audit of five Minimum Data Set assessments to validate Sections C0100, D, N0410G, M0300G2 and B0300 accuracy weekly x 4 weeks and then monthly x 2 months to ensure accuracy. Identified issues will be corrected upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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F 0641 SS=D	Continued from page 8 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for seven of 41 residents reviewed (Residents 15, 21, 22, 44, 63, 66, 75). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that the nurse was expected to listen to the resident, ask primary caregivers about the resident's speech, review the medical record, and determine the quality of the resident's speech. Section B0600 (Speech Clarity) was to be coded with a zero (0) for clear speech, a one (1) for unclear speech, and a two (2) for no speech. Section B0700 (Makes Self Understood)	F 0641		

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F 0641 SS=D	Continued from page 9 was to be coded zero (0) if the resident was understood, one (1) if the resident was usually understood, two (2) if the resident was sometimes understood, and three (3) if the resident was rarely/never understood. The section was not to be coded as rarely/never understood if the resident completed any of the resident interviews, as the interviews were conducted during the look-back period and should be factored in when determining the residents' ability to make himself/herself understood during the entire 7-day look-back period. Section B0800 (Ability to Understand Others) was to be coded zero (0) if the resident understands others, one (1) if the resident usually understands others, two (2) if the resident sometimes understands others, and three (3) if the resident rarely/never understands others. Section C0100 (Should a Brief Interview for Mental Status Be Conducted) was to be coded zero (0) No if the resident was rarely/never understood or one (1) Yes if the resident could participate in the interview. Section J0200 (Should Pain Assessment Interview Be Conducted) was to be coded zero (0) No if the	F 0641		

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F 0641 SS=D	Continued from page 10 resident was rarely/never understood and one (1) Yes if the resident interview should be attempted. Section D0100 (Should Resident Mood Interview be Conducted) was to be coded (0) No (resident is rarely/never understood) or (1) Yes (continue with interview). A quarterly Minimum Data Set (MDS) assessment (mandated assessments of a resident's abilities and care needs) for Resident 15, dated April 1, 2023, revealed that Section B0700 (Makes Self Understood) was coded with (2), indicating that the resident was sometimes able to be understood by others and Section B0800 (Ability to Understand Others) was coded two (2), indicating that she sometimes understood. However, Section C0100 was coded with a dash (-), indicating that the mental status interview was not attempted/assessed and Section D (Mood) was coded with a dash (-), indicating that the mood interview was not attempted/assessed. A quarterly MDS assessment for Resident 21,	F 0641		

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F 0641 SS=D	Continued from page 11 dated March 11, 2023, revealed that Section B0700 (Makes Self Understood) was coded with (2), indicating that the resident was sometimes able to be understood by others and Section B0800 (Ability to Understand Others) was coded two (2), indicating that she sometimes understood. However, Section C0100 was coded with a dash (-), indicating that the mental status interview was not attempted/assessed and Section D (Mood) was coded with a dash (-), indicating that the mood interview was not attempted/assessed. An interview with the Clinical Consultant on May 24, 2023 at 2:29 p.m. revealed that Residents 15 and 21's MDS were coded incorrectly and that sections C and D should have been completed. The RAI User's Manual, dated October 2019, indicated that the intent of Section N0410G was to be coded with the number of days the resident received a diuretic pill (a medication used to help the body get rid of extra fluid and salt).	F 0641		

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F 0641 SS=D	Continued from page 12 Physician's orders for Resident 22, dated April 27, 2021, included an order for the resident to receive hydrochlorothiazide (a diuretic) every day for edema (swelling). The resident's Medication Administration Record (MAR) for March 2023 revealed that the resident received hydrochlorothiazide every day during the seven-day look-back period. However, a quarterly MDS assessment for Resident 22, dated March 16, 2023, revealed that Section N0410G was coded zero (0), indicating that the resident did not receive a diuretic during the last seven days. An interview with the Clinical Consultant on May 24, 2023 at 2:29 p.m. confirmed that Resident 22's MDS was coded incorrectly and should have reflected that the resident was receiving a diuretic. The RAI User's Manual, dated October 2019, indicated that the intent of Section H0100 (Appliances) was to be coded with the number of days the resident used an appliance related to their	F 0641		

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F 0641 SS=D	Continued from page 13 toileting, such as an indwelling catheter, external catheter, ostomy, or intermittent catheterization (inserting a tube directly into the bladder to drain urine). Physician's orders for Resident 44, dated December 6, 2022, included an order for the resident to perform a straight catheterization (cath) on himself every shift for urinary retention. The Resident's MAR, dated April 2023, indicated that the resident straight cathed himself at least once a shift during the seven-day look-back period. However, a quarterly MDS assessment for Resident 44, dated April 20, 2023, revealed that Section H0100D (intermittent catheterization) was coded (0), indicating that the resident did not straight cath himself at least once a day during the last seven days. An interview with the Clinical Consultant on May 24, 2023 at 2:29 p.m. confirmed that Resident 44's MDS was coded incorrectly and should have reflected that he was straight cathed at least once daily during the seven-day look-back period and	F 0641		

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F 0641 SS=D	Continued from page 14 did not. The RAI User's Manual, dated October 2019, revealed that Section M0300G1 was to be coded with the number of unstageable pressure injuries related to a deep tissue injuries (area of purple or maroon discolored intact skin due to damage of underlying soft tissue). If Section M0300G1 was coded with a number, then the number of these unstageable injuries present upon admission/reentry was to be coded in section M0300G2. A quarterly MDS assessment for Resident 63, dated May 5, 2023, revealed that Section M0300G1 was marked "1" to indicate that the resident had one unstageable pressure ulcer related to a deep tissue injury. Section M0300G2 was marked "0" to indicate that the deep tissue injury was not present upon admission/readmission. However, a nursing note dated April 2, 2023, revealed that the resident returned to the facility via emergency medical sercives (EMS). The resident	F 0641		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 15 was noted to have a deep tissue injury to her right heel measuring 2.5 centimeters (cm) by 2 cm. Interview with the Director of Nursing on May 23, 2023, at 1:30 p.m. confirmed that Section M0300G2 of Resident 63's quarterly MDS assessment, dated May 5, 2023, was coded incorrectly. The RAI user's manual, dated October, 2019, revealed that Section A2100 was to be coded one (1) through (8) depending on the location of the resident's discharge. If the resident was discharged to the community (including a boarding home or assisted living facility) or home, then Section A2100 was to be coded one (1), and if the resident was discharged to an acute care hospital, then Section A2100 was to be coded three (3). A discharge note for Resident 66, dated April 18, 2023, revealed that the resident was discharged to an independent living facility.	F 0641		

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	396021	A. BLDG: 00 B. WING:	05/24/2023

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F 0641 SS=D	Continued from page 16 A discharge MDS assessment for Resident 66, dated April 18, 2023, revealed that Section A2100 was coded three (3), indicating that the resident was discharged to an acute care hospital. Interview with Director of Risk Management on May 24, 2023, at 3:40 p.m. confirmed that Section A2100 of Resident 66's discharge MDS assessment of April 18, 2023, was not accurate and should have been coded to indicate that the resident was discharged to the community. The RAI User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that for a resident with ability to hear, Section B0300 (Hearing Aid) was to be coded as one (1) if the resident used a hearing aid. A nursing admission screening observation note for Resident 75, dated May 8, 2023, indicated that the resident was admitted to the facility and there was	F 0641		

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F 0641 SS=D	Continued from page 17 no documentation of hearing aids being present on admission. Review of an admission MDS assessment, dated May 14, 2023, revealed that Section B0300 (Hearing Aid) was marked with a (1) yes. A witness statement, dated May 22, 2023, by the RNAC revealed that Resident 75 stated she wore hearing aides but had left them at home. The resident did not have hearing aides in place at the time the interview took place in her room. Resident 75 was in her wheelchair at bedside, was alert, and answered all questions appropriately. Interview with the Nursing Home Administator on May 25, 2023, at 10:32 a.m. confirmed that Section B0300 of Resident 75's MDS assessment of May 14, 2023, was not accurate, as the facility was not able to determine if the Resident 75 was admitted with hearing aids. 28 Pa. Code 211.5(f) Clinical records.	F 0641		

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F 0641 SS=D	Continued from page 18	F 0641		
F 0655 SS=E		F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0655 SS=E	Continued from page 19 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	1) Residents 77, 78 and 80 no longer reside in the facility. 2) A facility wide sweep was conducted to ensure that other residents receiving renal dialysis treatments, those with a diagnosis of end stage renal disease (kidney failure), diabetes (a condition that results when the body has a problem in the way it regulates sugar),hypothyroidism (when the body does not make enough thyroid hormones), anxiety, anticoagulant medication, insulin, impaired skin areas, antidepressants, and antianxiety medication have care plans to reflect their treatments and diagnoses. Identified issues were corrected at the time of discovery. In-house residents were provided with a copy of their updated care plans and evidence was documented in the medical records. Identified issues were corrected at the time of discovery. 3) Nursing staff and The Registered Nurse Assessment Coordinator (RNAC) were re-educated on the need to have baseline care plans	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0655 SS=E	Continued from page 20 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	completed with documented evidence that a copy was provided to the resident and or their representative. New staff and new agency staff will also receive this education. The need to develop a baseline care plan has been added to the admission check list (a check list to ensure that items needed as a part of the admission are completed). 4) The Director of Nursing or designee will audit the care plans of 5 admissions to ensure completion of the baseline care plan weekly x 4 weeks then monthly x 2 months to ensure accurate completion of the baseline care plan and documented evidence that a copy was provided to the resident and/or designee. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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F 0655 SS=E	Continued from page 21 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a baseline care plan was developed and implemented, and that a written summary of the baseline care plan was provided to the resident and/or the resident's representative for three of 41 residents reviewed (Residents 77, 78, 80) who were admitted on or after May 15, 2023. Findings include: The facility's policy regarding care plans, dated March 13, 2023, revealed that the licensed nurse will initiate a baseline care plan upon admission to facility and complete within 48 hours. The care plan will include the minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals based on admission orders, physician's orders, dietary orders, therapy orders, social services. The facility may develop a comprehensive care plan in place of the baseline care plan if developed within 48 hours. The facility will provide the resident and their representative	F 0655		

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F 0655 SS=E	Continued from page 22 with a summary of the baseline care plan that includes but is not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan, as necessary. A diagnosis list for Resident 77, dated May 18, 2023, revealed that the resident had a diagnosis which included dependence on renal dialysis (mechanical process that cleanses the blood when the kidneys are not functioning properly), end stage renal disease (kidney failure), and Type I diabetes (the pancreas makes little or no insulin) . Physician's orders for Resident 77, dated May 15, 2023, included an order for the resident to receive Calmoseptine ointment (a skin treatment) to the coccyx (tail bone) every day for impaired skin.. Physician's orders for Resident 77, dated May 18,	F 0655		

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F 0655 SS=E	Continued from page 23 2023, included an order for the resident to receive Humalog (a type of insulin) per sliding scale (the amount of insulin given depends of the level of the resident's blood sugar level). Physician's orders for Resident 77, dated May 18, 2023, included an order for the resident to receive 18 units of Glargine (a type of insulin) once a day. Physician's orders for Resident 77, dated May 18, 2023, included an order for the resident to receive 5 milligrams of Apixaban (anticoagulant/blood thinning medication) twice a day. A nursing note for Resident 77, dated May 18, 2023, indicated that the resident had redness and excoriation noted to the coccyx and buttocks, with an open area to right buttocks measuring 0.5 x 0.2 centimeters (cm). A nursing note for Resident 77, dated May 19, 2023, indicated that the resident was at dialysis and medication would be administered upon return.	F 0655		

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F 0655 SS=E	Continued from page 24 There was no documented evidence that Resident 77's baseline care plan (includes the minimum healthcare information necessary to properly care for a resident), dated May 18, 2023, included information about the resident's care needs related to the use of insulin, dialysis, and impaired skin areas to the buttocks. Interview with the Director of Nursing on May 23, 2023, at 1:34 p.m. confirmed there was no baseline care plan for Resident 77's dialysis needs related to kidney failure, the use of insulin for Type I diabetes, the use of anticoagulant medication, or for the care and treatment of a skin impairment. A diagnosis list for Resident 78, dated May 15, 2023, revealed that the resident had a diagnosis which included Type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) and anxiety. Physician's orders for Resident 78, dated May 15, 2023, included an order for the resident to receive	F 0655		

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F 0655 SS=E	Continued from page 25 one 50 milligram (mg) tablet of Trazadone (a medication to treat depression) at bedtime. Physician's orders for Resident 78, dated May 15, 2023, included an order for the resident to receive Novolog 70/30 (a type of insulin) per sliding scale (the amount of insulin given depends of the level of the resident's blood sugar level). There was no documented evidence that Resident 78's baseline care plan (includes the minimum healthcare information necessary to properly care for a resident), dated May 15, 2023, included information about the resident's care needs related to the use of antidepressant's and insulin, and there was no documented evidence that the resident and/or the resident's representative received a written summary of the baseline care plan. A diagnosis list for Resident 80, dated May 18, 2023, revealed that the resident had a diagnosis which included anxiety and hypothyroidism (when the thyroid gland does not make enough thyroid	F 0655		

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F 0655 SS=E	Continued from page 26 hormones to meet your body's needs). Physician's orders for Resident 80, dated May 18, 2023, included an order for the resident to receive 30 mg injection of Enoxaparin Sodium (a blood thinner) one time a day. Physician's orders for Resident 80, dated May 18, 2023, included an order for the resident to receive one 50 mg tablet of Sertraline (a medication to treat anxiety) one time a day. Physician's orders for Resident 80, dated May 18, 2023, included an order for the resident to receive one 15 mg tablet of Temazepam (a medication to treat anxiety) at bedtime. Physician's orders for Resident 80, dated May 18, 2023, included an order for the resident to receive one 50 microgram (mcg) tablet of Synthroid (a medication to treat hypothyroidism) one time per day.	F 0655		

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F 0655 SS=E	Continued from page 27 There was no documented evidence that Resident 80's baseline care plan, dated May 18, 2023, included information about the resident's care needs related to the use of hypothyroid, anticoagulant (blood thinners), and antianxiety medications, and there was no documented evidence that the resident and/or the resident's representative received a written summary of the baseline care plan. Interview with the Director of Healthcare Navigation on May 23, 2023, at 1:35 p.m. confirmed that Resident 78's baseline care plan did not include the use of antidepressant's and insulin, and that Resident 80's baseline care plan did not include the use of hypothyroid, anticoagulants, and antianxiety medications Interview with the Nursing Home Administrator on May 24, 2023, at 8:10 a.m. confirmed that there was no documented evidence that Residents 78 and 80 and/or their residents' responsible parties received a written summary of the residents' baseline care plan.	F 0655		

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F 0655 SS=E	Continued from page 28 28 Pa. Code 211.11(e) Resident care plan.	F 0655		
F 0656 SS=E		F 0656		

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F 0656 SS=E	Continued from page 29 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1) Resident 12 will have a care plan developed for the care and treatment of Type 2 diabetes, hypertension, depression, and the use of anticoagulant medications. Resident 16 will have a care plan developed to include the need for a Continuous Positive Airway Pressure (CPAP-device used to keep breathing airways open while you sleep). Resident 20 will have care plan updated to reflect the diagnosis of insulin dependent diabetes. Resident 22 will have their care plan updated to include their preferences regarding activities. 2) A sweep was conducted to ensure that other residents with diagnoses of Type 2 diabetes, insulin dependent diabetes, hypertension, depression, using anticoagulant medications, and using CPAP-devices have care plans to reflect their use. In addition, a sweep was conducted to ensure other residents have care plans to reflect their activities preferences. 3) The Registered Nurse Assessment Coordinator (RNAC)	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0656 SS=E	Continued from page 30 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	and Lifestyles staff were re-educated on the need to have comprehensive care plans developed accurately and timely. The RNAC will run the order listing report (a report within the electronic medical record that lists all new physician orders) on business days to double check that new orders have been care planned. 4) The Director of Nursing or designee will run the order listing report and check to ensure new orders and preferences are care planned on 5 residents weekly x 4 weeks then monthly x 2 months to ensure accurate care plan updates have occurred. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

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F 0656 SS=E	Continued from page 31 Based on clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized preferences regarding health care needs, oxygen needs, diabetes, and activities for four of 41 residents reviewed (Residents 12, 16, 20, 22). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated April 5, 2023, revealed that the resident was cognitively intact, required extensive assistance of staff for bed mobility, transfers, dressing, toileting, and hygiene and had diagnosis that included atrial fibrillation (rapid heart beat), hypertension (high blood pressure), and Type 2 diabetes. Physician's orders for Resident 12, dated April 29, 2023, included an order for the resident to receive 25 milligrams of Sertraline (antidepressant	F 0656		

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F 0656 SS=E	Continued from page 32 medication) once a day for depression. Physician's orders for Resident 12, dated April 29, 2023, included an order for the resident to receive 5 milligrams of Eliquis (anticoagulant medication) twice a day for hypertension. Physician's orders for Resident 12, dated April 29, 2023, included an order for the resident to receive 40 milligrams of Furosemide (diuretic medication) once a day for hypertension. Physician's orders for Resident 12, dated April 29, 2023, included an order for the resident to receive 1000 milligrams of metformin (diabetic medication) twice a day for Type 2 diabetes. Physician's orders for Resident 12, dated May 6, 2023, included an order for the resident to receive Lispro (a type of insulin) per sliding scale (the amount of insulin given depends of the level of the resident's blood sugar level). Interview with the Director of Health Care	F 0656		

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F 0656 SS=E	Continued from page 33 Navigator on May 24, 2023, at 2:16 p.m. confirmed that Resident 12 did not have care plans developed for the care and treatment of Type 2 diabetes, hypertension, depression, and the use of anticoagulant medications and should have been. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16, dated February 21, 2023, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, used supplemental oxygen, and had diagnosis that included chronic respiratory failure. Physician's order for Resident 16, dated March 11, 2023, included for the resident to use Continuous Positive Airway Pressure (CPAP-device used to keep breathing airways open while you sleep) on at bedtime and off in the morning. An interview with the Director of Nursing on May 23, 2023, at 10:14 a.m. confirmed that as of May 23, 2023, there was no care plan developed	F 0656		

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F 0656 SS=E	Continued from page 34 regarding Resident 16's use of a CPAP device. A quarterly MDS assessment for Resident 20, dated May 3, 2023, revealed that the resident was cognitively intact and had diagnoses that included diabetes with insulin dependence. There was no documented evidence that the resident's care plan, which was initiated on July 15, 2022, included a care plan for diabetes. Interview with the Director of Nursing on May 23, 2023 at 1:32 p.m. confirmed that Resident 20's care plan was not individualized regarding the resident's diabetes, and it should have been. A quarterly MDS assessment for Resident 22, dated March 16, 2023, revealed that the resident was cognitively intact and required extensive assistance from staff for daily care needs. An interview with Resident 22 on May 21, 2023, at 10:02 a.m. revealed that she would like more	F 0656		

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F 0656 SS=E	Continued from page 35 activities to be scheduled, especially on the weekends when there currently are none. There was no documented evidence that the resident's care plan, which was initiated January 24, 2021, included the resident's preferences regarding activities. Interview with the Activities Director on May 24, 2023 at 1:59 p.m. confirmed that Resident 22's care plan was not individualized regarding the resident's preference for activities, and it should have been. 28 Pa. Code 211.11(d) Resident care plan.	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 36 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1) Resident 16's care plan has been revised to resolve the urinary tract infection and antibiotic use. Resident 20's care plan has been revised to resolve the leg wound and leg wound infection. 2) A sweep was conducted of other resident care plans to ensure that resolved infections and healed impaired skin areas were resolved on the care plans. 3) The Registered Nurse Assessment Coordinator (RNAC) and intradisciplinary team were re-educated on the need to revise care plans timely. The RNAC will run the order listing report (a report within the electronic medical record that lists all new physician orders) on business days to double check that new orders have been care planned and or revised as applicable. 4) The Director of Nursing or designee will run the order listing report and check to ensure new orders are care planned on 5 residents weekly x 4 weeks then monthly x 2 months to ensure accurate care plan updates have	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0657 SS=D	Continued from page 37 Based on review of clinical records, facility policies, and interview of staff [illegible] 28 Pa. Code 211.12(c) resident care plans.	F 0657	occurred. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	
F 0658 SS=D		F 0658		

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F 0658 SS=D	Continued from page 38 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	1) Resident 12 had no adverse effects from not having a Registered Nurse (RN) assessment of a new impaired skin area that was noted on the left heel. Heel has been assessed by an RN. Resident 15 had no adverse effects from not having a Registered Nurse (RN) assess the resident when their head was bumped with a mechanical lift. 2) A facility wide sweep will be conducted going back 7 days to ensure that there was an RN assessment for any changes in condition. Concerns will be addressed upon discovery. 3) Licensed nursing staff will be re-educated on the need to have Registered Nurse (RN) assessments for changes in condition. New staff and new agency staff will also receive the education. The Registered Nurse Supervisor or designee will review the 24-hour report (an electronic summary of resident documentation) daily for changes of condition and ensure that an RN assessment was competed. Any identified issues will	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0658 SS=D	Continued from page 39 [illegible] 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0658	be addressed at the time of discovery. 4) The Director of Nursing or designee will conduct random audits of 5 residents via the 24-hour report for changes of condition and ensure that an RN assessment was competed weekly for 4 weeks then monthly for 2 months. Identified issues will be addressed at the time of discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	1) Resident 45 had their facial hair removed. 2) A sweep was conducted to ensure other female residents with unwanted facial hair were identified and residents were assisted to remove their unwanted facial hair. 3) Nursing staff were re-educated on the importance of assisting residents with the removal of unwanted facial hair. New staff and new agency staff will also receive this education. Resident tasks will be updated to include the removal of unwanted facial hair. 4) Director of Nursing or designee will round on 10 residents to ensure unwanted facial hair has been removed weekly x 4 weeks then monthly x 2 months. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0677 SS=D	Continued from page 41 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that dependent residents were provided with the necessary services to maintain personal grooming, by failing to keep a female resident free of facial hair for one of 41 residents reviewed (Resident 45). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 45, dated April 27, 2023, revealed that the resident was cognitively impaired, required extensive assistance from staff for personal hygiene, and had diagnosis that included complete atrioventricular block (a type of heart rhythm disorder). Observations of Resident 45 on May 21, 22, and 23, 2023, during lunch meal service revealed the resident sitting in her wheelchair in the dining room	F 0677		

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F 0677 SS=D	Continued from page 42 with other residents, visitors, and staff around her, with multiple light-colored hairs, approximately one quarter of an inch long on her chin. There was no documentation in the clinical record to indicate that the resident refused to have personal hygiene or shaving completed. Observations on May 24, 2023, at 10:08 a.m. revealed that she was sitting in her wheelchair in the hallway with no noticeable facial hair. An interview with Nursing Assistant 1 on May 23, 2023, at 12:20 p.m. confirmed that facial hair was present on Resident 45's chin and that it should not be there. An interview with the Director of Nursing on May 23, 2023, at 1:07 p.m. confirmed that female residents should not have noticeable hair on their chin for three consecutive days. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0677		

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F 0679 SS=D		F 0679		

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F 0679 SS=D	Continued from page 44 483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 0679	1) Staff reviewed Residents #8; #20; #22; and #48 assessments to ensure activity preferences are being met and available to residents. 2) Lifestyles Director and/or designee will conduct a whole-house sweep of activity assessments to review and ensure all in-house residents' preferences are being addressed in resident's plan of care and also aligning with the activity department's generated activity calendar. 3) Lifestyles Director and/or designee will generate an activities calendar with scheduled, organized activities on the weekend and /or evenings. Activity staff will be educated by Nursing Home Administrator on activity assessment accuracy with residents. 4) Nursing Home Administrator and/or designee will monitor the activity calendars to ensure organized and scheduled activities are being held on the weekend and available during evening hours. This will be done monthly x3. 5) Audit results will be reported to	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0679 SS=D	Continued from page 45 Based on review of facility policy, staff and clinical [illegible] 28 Pa. Code 211.12(d)(5) Nursing services.	F 0679	the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 46 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1) Resident 16 had no adverse effects from having low blood pressures and having antihypertensive medication (a medication to lower blood pressure) held without notifying the resident's physician. The physician was updated on condition, vital signs and made aware of held doses. 2) A facility wide sweep going back 14 days on current in-house residents will be conducted to ensure that any residents who had blood pressure medications held or systolic blood pressures less than 100 had physician notification of the low blood pressure and/or medications being held. Concerns will be corrected upon discovery. 3) Licensed nurses, including current agency staff were re-educated on the need to notify physicians when medications are held and when systolic blood pressures are less than 100. New staff and new agency staff will also receive this education. The Director of Nursing or designee will review the 24-hour report (an electronic	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: __00_____ B. WING: _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE GREENSBURG, PA 15601**

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F 0684 SS=D	Continued from page 47	F 0684	summary of resident documentation) daily for doses of medication that were held and ensure that the physician was notified. Any identified issues will be addressed at the time of discovery. 4) The Director of Nursing or designee will conduct an audit of medications held requiring physician notification weekly x 4 weeks and then monthly x 2 months. Concerns will be addressed upon discovery.	

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F 0684 SS=D	Continued from page 48 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a physician was notified of low blood pressures and medications being held for one of 41 residents reviewed (Resident 16). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16, dated February 21, 2023, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, used supplemental oxygen, and had diagnosis that included chronic respiratory failure. Physician's orders for Resident 16, dated February 14, 2023, included for the resident to receive 25 milligrams (mg) of Metoprolol Tartrate (used to treat high blood pressure) two times a day for hypertensive heart disease (heart disease caused by high blood pressure).	F 0684		

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F 0684 SS=D	Continued from page 49 A nurse's note for Resident 16, dated March 3, 2023, at 6:51 a.m. revealed that the resident had a low blood pressure of 86/50 millimeters of mercury (mm/Hg). Review of the Medication Administration Record (MAR) for Resident 16 for March 2023 revealed documentation of the following low blood pressures: March 2 on night shift was 86/50 mm/Hg; March 6 on evening shift was 99/60 mm/Hg; March 7 on day shift was 98/62 mm/Hg; March 7 on evening shift was 98/62 mm/Hg; March 7 on night shift was 91/60 mm/Hg; and March 8 on night shift was 99/65 mm/Hg. Review of the MAR also revealed that the resident's metoprolol was not administered on March 1 at 8:00 a.m. and March 5, 6, and 7 at 10:00 p.m. There is no documented evidence in Resident 16's clinical record to indicate that the physician was notified of the above-mentioned low blood pressures or the Metoprolol doses that were not	F 0684		

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F 0684 SS=D	Continued from page 50 administered. An interview with the Director of Nursing on May 23, 2023, at 10:14 a.m. confirmed that there was no documented evidence that the physician was notified of Resident 16's low blood pressures or the Metoprolol doses that were not administered. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		
F 0688 SS=E		F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0688 SS=E	Continued from page 51 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1) A rehab screen will be completed for resident 5 to assess current range of motion status and current restorative or rehab program needs. A rehab screen will be completed for resident 17 to assess current functional mobility and restorative or rehab program needs. A rehab screen will be completed for resident 45 to assess ambulation status and restorative or rehab program needs. 2) A sweep will be conducted of other residents with care plans for a restorative nursing program. Affected residents will have a rehab screen completed to determine their current functional status and need for restorative or rehab nursing services. 3) A nurse will be designated to oversee the restorative program. They will be educated on restorative nursing and the need to determine a resident's ability to participate and re-evaluate to determine the effectiveness of the program. 4) The Director of Nursing or designee will conduct an audit of	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0688 SS=E	Continued from page 52	F 0688	resident documentation to ensure that residents with a restorative nursing program are having documentation completed and re-evaluations to determine ability for participation weekly x 4 weeks and then monthly x 2 months. Concerns will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0688 SS=E	Continued from page 53 Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure the provision of restorative nursing to maintain and/or to prevent a decline in range of motion for three of 41 residents reviewed (Residents 5, 17, 45). Findings include: The facility's policy regarding Restorative Nursing, dated March 13, 2023, revealed that residents will receive restorative nursing care as needed to help promote optimal safety and independence. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated April 13, 2023, revealed that the resident was cognitively impaired, required extensive assist assistance from staff for personal hygiene, and had diagnosis that included dementia. Resident 5's care plan, dated November 26, 2020,	F 0688		

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F 0688 SS=E	Continued from page 54 indicated that the resident was at risk for decline in functional ability and she will perform active assisted range of motion (AAROM) to all joints to maintain strength, endurance and functional ROM abilities once daily as tolerated. The resident's care plan included an intervention for the resident to receive AAROM to all joints to decrease the risk of contracture and maintain/improve range of motion ability once daily. There was no documented evidence of restorative range of motion being completed for Resident 5, and there was no evidence that the resident's range of motion had been assessed to determine if the resident was participating in the restorative nursing program. An annual MDS assessment for Resident 17, dated April 26, 2023, indicated that the resident was cognitively impaired and required assistance from staff for daily care needs. Resident 17's care plan, dated June 15, 2020, indicated that the resident was at risk for decline in functional ability and she will	F 0688		

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F 0688 SS=E	Continued from page 55 maintain mobility and endurance to achieve maximum level of independence/safety without evidence of increased falls by ambulating once daily as tolerated. The resident's care plan, dated June 15, 2020, revealed that the resident would walk 80 feet with a minimum assistance of one staff and a wheeled walker. The resident's task list indicated that the resident was to walk 10 feet every shift, walk 150 feet with two turns, roll right and left and return to lying on back on the bed, would wheel 150 feet once seated in wheelchair/scooter, and wheel 50 feet with two turns once seated in wheelchair/scooter. There was no documented evidence in the clinical record of restorative programs being provided to Resident 17. The resident's task list was not completed consistently and there was no evidence that the resident's ability to walk, turn herself in bed, or wheel herself in her chair had been assessed to determine if the resident was participating in the restorative nursing program.	F 0688		

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F 0688 SS=E	Continued from page 56 An annual MDS assessment for Resident 45, dated April 27, 2023, revealed that the resident was cognitively impaired, required extensive assistance from staff for personal hygiene, and had diagnosis that included complete atrioventricular block (a type of heart rhythm disorder). Resident 45's care plan, revised May 11, 2023, indicated that the resident was at risk for decline in functional ability and she will maintain mobility and endurance to achieve maximum level of independence/safety without evidence of increased falls by ambulating once daily as tolerated. The resident's care plan intervention, dated April 22, 2021, revealed that the resident would walk 50 feet with a minimum assistance of one staff and a wheeled walker with a wheelchair following her. The resident's task list indicated that the resident was to be walked 10 feet every shift, walk 150 feet with two turns. There was no documented evidence in the clinical record of restorative ambulation for Resident 45.	F 0688		

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F 0688 SS=E	Continued from page 57 The resident's task list was not completed consistently and there was no evidence that the resident's ability to walk had been assessed to determine if the resident was participating in the restorative nursing program. Interview with the Health Navigator on May 24, 2023, at 10:00 a.m. confirmed that the facility no longer had a full restorative program and that there was no clear way to determine if a resident is participating in a restorative nursing program or if they are unable to participate. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0688		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 58 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1) Residents 16, 20, and 23 had physician orders added to include the use of and cleaning of their Continuous Positive Airway Pressure-CPAP-devices (used to keep breathing airways open while you sleep). Their care plans were also updated to reflect their use and cleaning. 2) A sweep was conducted to ensure that other residents using CPAP-devices had physician orders and care plans for their use and cleaning. 3) Licensed nurses were re-educated on the need to have physician orders and care plans for CPAP-device use and cleaning. New staff and new agency staff will also receive this education. CPAP-devices were added to list of items to be reviewed during the daily clinical meeting to ensure orders and care plans are in place. 4) The Director of Nursing or designee will conduct an audit of CPAP-device orders and care plans weekly x 4 weeks and then monthly x 2 months to ensure completion.	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0695 SS=D	Continued from page 59 Based on review of facility policies and interviews [illegible] 28 PA Code 211.12(d)(5) Nursing services."	F 0695	Concerns will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	
F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 60 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	1) Physician orders were obtained for resident 77 to receive dialysis treatments and monitoring of the access sites. 2) A sweep was conducted to ensure other residents receiving dialysis treatments had physician orders for the treatments and monitoring of access sites. 3) Licensed nurses were re-educated on the need to have physician orders for dialysis treatments and monitoring of access sites. New staff and new agency staff will also receive this education. Dialysis treatments were added to list of items to be reviewed during the daily clinical meeting to ensure orders are in place for the treatments and monitoring of the access sites. 4) The Director of Nursing or designee will conduct an audit of dialysis orders weekly x 4 weeks and then monthly x 2 months to ensure completion. Concerns will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0698 SS=D	Continued from page 61	F 0698	trends and further opportunities for quality improvement and needs for additional education.	

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F 0698 SS=D	Continued from page 62 Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to obtain physician's orders for dialysis or for the care and monitoring of dialysis sites for one of 41 residents reviewed (Resident 77). Findings include: The facility's policy regarding care for residents who receive dialysis (mechanical process that cleanses the blood when the kidneys are not functioning properly), dated March 13, 2023, revealed that the hemodialysis procedure would be under the direct responsibility and supervision of the contracted dialysis agency. The outpatient dialysis service agreement, signed August 23, 2013, indicated that both the facility and outpatient dialysis facility would mutually develop a written protocol governing specific reponsibilities, policies, and procedures to be used in rendering dialysis services to residents at the dialysis unit,	F 0698		

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F 0698 SS=D	Continued from page 63 including but not limited to, the development and implementation of a resident's care plan relative to the provision of dialysis services. A nursing note for Resident 77, dated May 18, 2023, indicated that the resident was admitted to the facility with a right subclavian catheter (a deep central vein from the axillary vein that joins the internal jugular vein under the clavicle) with a dressing that was dry and intact. A nursing note for Resident 77, dated May 21, 2023, indicated that the resident had a right chest double lumen dialysis site with a dressing in place. A nursing note for Resident 77, dated May 19, 2023, indicated that the resident was at dialysis and medication would be administered upon return. Interview with Resident 77 on May 23, 2023, at 12:04 a.m. revealed that she went to dialysis on May 22, 2023; she received dialysis through the port on her chest; and she has a fistula (surgical dialysis access site) on her right arm, but it has not been accessed.	F 0698		

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	396021	A. BLDG: __00_____ B. WING: _____	05/24/2023

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F 0698 SS=D	Continued from page 64 There was no documented evidence that staff monitored the dialysis site, and there was no documented evidence that physician's orders were obtained for hemodialysis services or for monitoring the access sites. Interview with the Director of Nursing on May 23, 2023, at 1:34 p.m. confirmed that there was no documented evidence that physician's orders for dialysis services or for monitoring Resident 77's s dialysis access sites were obtained, and no documented evidence that the dialysis sites were being monitored. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0698		
F 0773 SS=D		F 0773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0773 SS=D	Continued from page 65 483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 0773	1) Resident 83 had no adverse effects from being straight catheterized to obtain urine specimen without a physician order. 2) A sweep will be conducted going back 7 days to ensure other residents who were straight catheterized had a physician order to do so. Identified issues will be corrected at time of discovery. 3) Licensed nurses were re-educated on the need to have physician orders for invasive procedures such as straight catheterizations. New staff and new agency staff will also receive this education. The nurse conducting the 24-hour check will ensure there were physician orders obtained for any urinary catheterizations. Identified issues will be addressed at the time of discovery. 4) The Director of Nursing or designee will conduct an audit of orders for urine cultures weekly x 4 weeks and then monthly x 2 months to ensure orders were recieved if straight catheterization was required. Concerns will be addressed upon	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0773 SS=D	Continued from page 66	F 0773	discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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F 0773 SS=D	Continued from page 67 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to obtain a physician's order for an invasive procedure to collect a specimen for a laboratory test for one of 41 residents reviewed (Resident 83). Findings include: An admission nursing note for Resident 83, dated April 29, 2023, revealed that the resident was confused with a diagnosis that included dementia and was continent of bowel and bladder. A nursing note for Resident 83, dated May 4, 2023, revealed that the resident's daughter reported to staff that the resident was having increased hallucinations. Staff were waiting for the resident to urinate so that it could be collected for testing, but the resident did not void. Resident 83 was straight catheterized (an invasive procedure in which a plastic tube is inserted into the bladder) to obtain the urine.	F 0773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0773 SS=D	Continued from page 68 There was no documented evidence in the clinical record to indicate that staff obtained a physician's order to collect Resident 83's urine specimen via catheterization. Interview with the Director of Health Navigation on May 24, 2023, at 8:50 a.m. confirmed that there was no evidence that a physician's order was obtained for Resident 83 to be straight catheterized in order to obtain the urine specimen. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0773		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 69 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1) Food Service Manager and/or designee removed and discarded the chocolate milk, salad, tenderloin, hard salami, vegetable blends, and dry storage that was cited on 5/21/23 2) Food Service Manager and/or designee did a sweep of the kitchen to ensure proper food storage; to ensure no unlabeled and undated food; and to ensure no expired products were present. 3) General Manager and / or designee educated the dietary staff on proper food storage and reviewed the food labeling and dating policy with the dietary department. Food Service Manager and/or designee will conduct food labeling and dating audits daily x2 weeks and then weekly x2 months to ensure compliance. 4) Food Service Manager and/or designee will conduct storage audits daily x2 weeks and then weekly x2 months to ensure compliance. Identified items will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=E	Continued from page 70	F 0812	Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

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F 0812 SS=E	Continued from page 71 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food items were stored in accordance with professional standards for food service safety in the walk-in freezer, walk-in coolers, and the dry storage in the main kitchen. Findings include: The facility's policy regarding labeling and dating food, dated March 13, 2023, indicated that all foods were labeled with the name, use by dated, prepared and opened date to ensure food safety. The facility's policy regarding food storage, dated March 13, 2023, revealed that all food stored in dry storage would be at least six inches above the floor. Staff are to cover, label, and date unused portions and opened packages. Foods past the "use by," "sell by," "best by," or "enjoy by" dates should be discarded. Raw foods and cooked foods should be separated with cooked foods being stored above raw foods.	F 0812		

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F 0812 SS=E	Continued from page 72 Observations in Walk-In Refrigerator 3 on May 21, 2023, at 9:44 a.m. revealed an opened and undated quart of chocolate milk with a best-by date of May 18, 2023. Observations in Walk-In Refrigerator 2 on May 21, 2023, at 9:49 a.m. revealed a bowl of staff-prepared ambrosia salad being stored under a large pan of raw beef tenderloin, and a 40-ounce opened and undated package of hard salami. Observations in the walk-in freezer on May 21, 2023, at 9:52 a.m. revealed one opened and undated bag of frozen chef gold vegetable blend and a 20-pound box of mixed vegetables that were open and exposed to air and undated. Observations of the dry storage area on May 21, 2023, at 9:54 a.m. revealed a box of Frito Lay individual smart popcorn bags and a box of snack pack pudding stored directly on the floor. Interview with the Dietary Manager on May 21, 2023, during the tour of the food storage areas, confirmed that expired foods should be disposed of; prepared foods should not be stored under raw meats; all food packages should be labeled, dated,	F 0812		

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F 0812 SS=E	Continued from page 73 and sealed after opening; and dry foods should be stored above the floor. 28 Pa. Code 211.6(f) Dietary services.	F 0812		
F 0867 SS=E		F 0867		

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F 0867 SS=E	Continued from page 74 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	1) The Quality Assurance Performance Improvement Committee will evaluate effectiveness of plan of correction interventions through data review, trend identification and root cause analysis, with emphasis on repeat concerns. 2) Residents who reside in the facility have the potential to be affected by the deficient practice. 3) The facility will implement measures to prevent this practice from recurring, including: a. Administrator, and Director of Nursing were re-educated regarding the requirements of the Quality Assurance Performance Improvement Process. b. Quarterly agenda items for the Quality Assurance Performance Improvement c. Committee will include areas that are high risk, high volume and problem prone, as well as quality of care outcomes, grievance/concern trends, resident council feedback, prior survey issues and observations from other facility	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0867 SS=E	Continued from page 75 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867	committees. 4) The administrator or designee will monitor corrective actions to ensure effectiveness of these actions including: a. The results of the audits of the plan of correction monitoring will be presented in the Quality Assurance Performance Improvement Meeting quarterly. b. To prevent the occurrence of repeat concerns, the Quality Assurance Performance Improvement Committee will maintain a three year survey calendar to review previous deficiencies and review for compliance. 5) The Administrator or designee will oversee the compliance of this Plan of Correction.	

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F 0867 SS=E	Continued from page 76 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=E	Continued from page 77 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on review of the facility's plan of correction [illegible] 28 Pa. Code 201.18(e)(4) Management of licensee.	F 0867		
F 0887 SS=D		F 0887		

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F 0887 SS=D	Continued from page 78 483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 0887	1) Residents 71 and 80 no longer reside in facility. Resident 60's representative will be educated on the risks versus benefits of the COVID-19 vaccine. This has been documented in the medical record. 2) Other residents/resident representatives who refused the COVID-19 vaccination will be educated on the risks versus benefits of the COVID-19 vaccine and this will be documented in the medical record. 3) License nursing staff will be re-educated on the requirement to offer the COVID-19 vaccine and provide education about the COVID-19 vaccine including the risks versus benefits. New staff and new agency staff will also receive this education. Educational material will be provided upon admission about the COVID-19 vaccines and their risks versus benefits. This will be documented in the medical records. This will be tracked as a part of the admission checklist to ensure completion. 4) The Director of Nursing or	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396021	A. BLDG: 00 B. WING:	05/24/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: **073202**	**6 GARDEN CENTER DRIVE** **GREENSBURG, PA 15601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0887 SS=D	Continued from page 79 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887	designee will conduct an audit of COVID-19 vaccine refusals to ensure education was provided and documented weekly x 4 weeks and then monthly x 2 months to ensure orders were recieved if straight catheterization was required. Concerns will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 80 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to offer, or provide education regarding the benefits, risks, and potential side effects of the COVID-19 vaccine for three of five residents reviewed for immunizations (Residents 60, 71, 80). Findings include: Review of the policy regarding Infection Control-Vaccination for COVID-19, dated March 13, 2023, indicates that the facility will educate residents on the risks and benefits of the COVID vaccines, offer to administer the vaccine, and report vaccination data to Center for Disease Control's (CDC) National Healthcare Safety Network. Data will be collected upon admission to determine if a resident has been fully vaccinated against COVID-19. COVID-19 vaccination and handwashing education will be provided upon admission. If applicable the COVID-19 vaccine or	F 0887		

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F 0887 SS=D	Continued from page 81 booster will be offered. Nursing will obtain a physician order for the applicable vaccine; nursing will complete the Vaccine Administration Record Informed Consent for Vaccination in Long Term Care Facility form and send it to the identified staff who will keep a log of residents requesting the vaccine. The vaccine will be ordered on Monday, delivered on Thursdays, and administered on Friday. Review of the clinical record revealed that Resident 60 was admitted to the facility on January 9, 2022. A review of the resident's COVID tracker record done on admission revealed that the resident had previously refused the COVID vaccine. As of May 24, 2023, there was no documented evidence that the resident was offered education regarding the risks and benefits of the COVID vaccine or the COVID vaccination. Review of the clinical record revealed that Resident 71 was admitted to the facility on May 19, 2023. A review of the resident's COVID tracker record	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 82 done on admission revealed that the resident had previously refused the COVID vaccine. As of May 24, 2023, there was no documented evidence that the resident was offered education regarding the risks and benefits of the COVID vaccine or the COVID vaccination. Review of the clinical record revealed that Resident 80 was admitted to the facility on May 18, 2023. A review of the resident's COVID tracker record done on admission revealed that the resident had previously refused the COVID vaccine. As of May 24, 2023, there was no documented evidence that the resident was offered education regarding the risks and benefits of the COVID vaccine or the COVID vaccination. Interview with the Director of Nursing on May 24, 2023, at 4:15 p.m. confirmed that there was no documented evidence that Residents 60, 71 and 80 were offered education regarding the risks and benefits of the COVID vaccine or the COVID vaccination.	F 0887		

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F 0887 SS=D	Continued from page 83 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0887		

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P 0525	§ 201.18(f) Management. (f) A written record shall be maintained on a current basis for each resident with written receipts for personal possessions and funds received or deposited with the facility and for expenditures and disbursements made on behalf of the resident. The record shall be available for review by the resident or resident's responsible person upon request. This REGULATION is not met as evidenced by:	P 0525	1) Resident 75 will have their personal belongings inventory updated. The process has been initiated for facility to replace the missing hearing aids. 2) A sweep was conducted to complete inventory sheets for other residents. 3) Nursing staff were re-educated on the need to complete and maintain accurate inventory sheets for residents. New staff and new agency staff will also receive this education. Inventory sheet monitoring will be added to the admission check list to ensure it is not missed. 4) The Director of Nursing or designee will conduct an audit of admission audits on 5 residents weekly x 4 weeks and then monthly x 2 months to completion. Concerns will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.	Completion Date: **06/19/2023** Status: **APPROVED** Date: **06/13/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 0525	Continued from page 1 Based on clinical record reviews and staff interviews, it was determined that the facility failed to maintain a complete and accurate record of the residents' personal possessions on admission and during the residents' stay for one of 41 residents reviewed (Resident 75). Findings include: An interview with Resident 75 on May 21, 2023, at 1:01 p.m. revealed that while she was being assisted in bed her hearing aides fell out and she has not had them since. Review of the clinical record for Resident 75 revealed that she was admitted to the facility on May 8, 2023. There was no documented evidence to indicate that an inventory of personal possessions form was completed on admission. Interview with the Nursing Home Administator on May 25, 2023, at 10:32 a.m. confirmed that the	P 0525		

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P 0525	Continued from page 2 facility was unable to find the inventory sheet for Resident 75. Her son reported the missing hearing aides to the receptionist and the process has been transferred to the concern log for investigation.	P 0525		

Certified End Page

REDSTONE HIGHLANDS HEALTH CARE CTR

STATE LICENSE NUMBER: 073202

SURVEY EXIT DATE: 05/24/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY